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## NASAL CATARRH.

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BY F. C. CORNWALL, M. D., SAN FRANCISCO, CALIFORNIA,

*Prof., of Diseases of the Eye, Ear and Throat, in California Medical College.*

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Having in my previous article in a brief manner given my views of the causes of nasal catarrh I will now attempt to describe the different conditions in which it may exist. In order to do this it will be necessary, first, to give the characteristic anatomy of this part of the respiratory organs. The nostrils is the point of entrance of air into the lungs. There are three bones (called turbinate from their shape) in each nostril which have a shape designed to prevent the passage of air directly into the throat and lungs.

There are two objects to be attained by this! First, odoriferous particles in the atmosphere are deposited upon the

terminals of the olfactory nerves in the upper part of the nostrils, and second the air is warmed before it passes further into the respiratory passages; and also dust or any foreign particles are deposited on the mucous membrane, the nostrils thus acting as a sieve to purify the air for farther use in the lungs.

These turbinated bones are covered by a mucous membrane which has characteristics different from any other mucous membrane. The point of dissimilarity is in the sub-mucous layer which is, in ordinary mucous membrane, sub-mucous areolar tissue, whose cells are filled with air, while those under consideration are filled with blood and are designed for a wholly different purpose. When, for any reason it is desirable for protection of the lungs or throat that the volume of air be limited, or that it be more than commonly warmed, through the influence of the sympathetic nerves these blood caverns become engorged with blood and the lumen of the nostrils lessened. Thus it will be seen that the nostrils have to stand the brunt of all that is irritant in the atmosphere which renders it unfit to be respired.

Upon the understanding of this peculiar anatomy depends all that is of practical importance in the treatment of nasal diseases; and it is only recently that the profession have made themselves completely acquainted with the pathology of this part consequent upon its peculiar structure.

There are various influences, some intrinsic and some extraneous, which tend to an abnormal engorgement of these blood caverns. The intrinsic causes, to which I have already referred in my chapter on causes, are inherent in the nervous system. Persons who habitually have too much blood about the face, as evidenced by redness, and who often have correspondingly too little in their extremities, are almost sure to have too much blood in the caverns of the turbinated mucous membrane. This in time induces irritation of the mucous glands which are partly imbedded in this part, the result of which is an increased flow of mucus. Eventually the mucous membrane becomes sensitive to atmospheric changes and

the individual is properly said to have catarrh.

There are those called by the profession neurasthenic, whose temperaments are such as to render them subject to a number of morbid phenomena, as hyperesthetic conditions of parts; as instances the reproductive organs, the eyes, or may be the nose. In the latter case it may be "Hay Fever" in reality, but there are very many cases which may not embody a sufficient number of the characteristics of this affection to be classed with it, but still, pathogenically, there are no great differences. In these cases the nasal mucous membrane is morbidly sensitive to certain extraneous influences, either of particles floating in the atmosphere, or temperature changes. The cavernous tissue beneath is more or less abnormally influenced by this perverted state of the local nerves and so the individual is apt to sneeze and blow and hawk considerably and be painfully aware of the presence of his proboscis. Among the extraneous cause may be noted irritants in the atmosphere. As previously mentioned the nose is the sifter of the air for the respiratory organs and all that is unfit for entrance into their tubes is lodged against the mucous membrane of the nasal cavities. As a consequence the inhabitants of localities in which there is much dust become afflicted with nasal catarrh. Where there is much humidity, as in parts of Europe, if there be nasal disease it will not be from this cause.

It has been my purpose to speak mostly of the characteristics of this disease in America among Americans. In Europe the conditions are quite different from those in this country and consequently the diseases have not the same characteristics. What are commonly called "blood diseases" figure more conspicuously there. In this case there will be organic tissue changes in the turbinated region, but the source of irritation is not the same. But going back to the subject of congestion of the turbinated region through influences either extraneous or intrinsic or both. After a time this unnatural engorgement induces deposits of new material and this usually in the interstices of the blood caverns. The

cells themselves become enlarged and their walls thickened, losing their contractile power until when empty of blood they still retain their shape instead of collapsing as they do in their normal condition. This then, is what may be called hypertrophic catarrh and may progress to such an extent that the blood cells become almost obliterated and localities so changed as to constitute what are called neoplasms.

There is another form of nasal disease whose etiology is much more obscure viz: atrophic or dry catarrh. This is a condition in which the secretion is tenacious and dry and adheres to the surface of the turbinate mucous membrane, remaining for days. It can not be said that those who are afflicted with this disease are stronuous or that they are subjects of inherited specific disease, although I have suspected that some cases are remotely connected with a cachexia of the latter kind. It seems a disease not associated with any noticeable constitutional impairment in the average case, but from the fact that a number of the members of one family are often afflicted with it it must be inherited. It might be inferred from this that it was contagious but my observation would not carry out such an opinion inasmuch as the offspring bearing a resemblance to the parent who had the disease were the ones afflicted by it, while those who resembled the parent not diseased in this way would be free from it.

The pathology of atrophic catarrh is interesting. The disappearance of the turbinate bones—a chief characteristic—is not due to necrosis or ulceration but, it appears, by pressure and absorption. The secretion resembles glue and no doubt owes its tenaciousness to the similarity of its constituents. Its action on the turbinate bones is that of collodion contracting as it dries and thus squeezing the life out of the parts it surrounds. The epithelium of the whole mucous membrane and the mucous glands of the nasal cavities is likely involved and the process might be termed an ulceration of the epithelium or an epithelial ulcer. The mucous glands pour out a copious secretion which also ex-

udes from the whole surface and which is constituted of an excess of albumen or rather lacks in its watery constituents, and this becomes mixed with the rapidly proliferated and short lived cells. When this tenacious secretion, after remaining till dry, is removed from the part the mucous membrane is more or less denuded of its epithelium and is a bleeding surface.

There are two forms of dry catarrh; one which is primarily atrophic and another which begins as an hypertrophic, and ends in an atrophic process. It is my observation that the first form is hereditary as has been above noted. In this case it begins in youth if not in infancy and there is almost always offensive odors even when the secretions are recent. In the second form there are no bad odors unless the secretions are retained until decomposition takes place. There will remain some hypertrophic patches and other portions will undergo atrophy, producing as a consequence large cavities for the accumulation of the secretions.

I will now recapitulate. There are three principal forms of the disease which is usually called nasal catarrh: 1st. *Simple Chronic Catarrh* in which there is more or less continuous engorgement of the cavernous layer of the mucous membrane of the turbinate region. 2nd. *Chronic Hypertrophic Catarrh*, a condition in which this cavernous layer has become organized more or less into a new formation and some parts greatly enlarged. 3rd. *Chronic Atrophic Catarrh* characterized by a tenacious odorous secretion and wasting of the soft bones of the nose.

There are many other nasal diseases which are to be treated by the nasal specialist and which have to do in keeping up discharges and reflex disturbances etc. etc. such as nasal polypi, caries and necrosis of the turbinate bones and septum and ecchoudromata and exostoses of the septum.

The most important part, and the part the reader will pursue with the most interest, is to be told viz. the cure. It will now be necessary to go back to the causes of these diseases in order to direct the treatment. The first in order will be

the congestive form. Here we have the temperamental peculiarity which predisposes to the excessive amount of blood in the head and consequently in the turbinated mucous membrane. Here your skill as a general diagnostician will be put to the test. You will need to determine how much of this is inherent in the individual and how much has been brought about by modes of life or by affections of other organs which may temporarily disturb the sympathetic nervous system. You must remember this is so often an affection of the vasomotor nerves and if there is a disturbed condition of the reproductive organs such as menstrual troubles, or irritation from misuse of the sexual function in either sex. In any of these cases these disturbing elements must receive attention and to direct the proper habits of life of these individuals, besides their medical treatment, requires considerable wisdom.

Those who suffer with poor capillary circulation with cold extremities and congestion about the head may require instruction in proper habits of exercise and care of the skin, such as morning baths and self massage and the avoidance of the prolonged hot bath which is unphysiological and always harmful. Even when these conditions are inherent much may be done to overcome them. You are to study the ancestral environment of the individual which has brought about such a condition of the offspring and particularly in the young to strive to have such different conditions as occupation and climate would bring about chosen for your patient. No little care should be paid to ventilation of sleeping apartments and clothing. So far as local astringent applications are concerned, and for reasons which I hope all may understand, they are of no permanent benefit. On the other hand they are almost always harmful. Only the mildest of medicaments are harmless such as very dilute solutions of carbolic acid, boracic acid, borax, etc. etc. Combinations of these remedies are useful at times to cleanse the parts but so far as curing they never do. Cocaine is occasionally curative but so far as being able to direct the

case in which it may be used I can not. It must not be used to long as it may destroy the sense of smell or encourage a cocaine habit. After constitutional management has failed resort will have to be made to the alterative effect of cantery. The turbinated bodies will be found on inspection to be engorged so as to nearly fill the nasal fossæ. The cantery to be used is presumably to be from a galvano cantery battery and the electrode is to be applied to the center of these enlarged bodies at a red heat and sunk nearly to the bone. Limited portions should be treated in this way after the part has been completely abtunded by a saturated solution of cocaine and if the effect be salubrious continue until there is a cure. It is not often necessary to go over the whole of the turbinated region. When the worst portions have been cured the remainder will usually succumb.

Hypertrophic catarrh has almost always past the causation or developmental period and hence constitutional attention is but little needed. The cause has usually passed away and you have only to treat the effect. This is in the shape of enlarged parts which may be called neoplasms, and which are to be destroyed according to the most convenient method at hand.

This may be by the cold snare, or the galvano cantery snare, or galvano cantery knife, or flat electrode, or by the scissors, or by chemical caustics. Every surgeon must be his own judge which measure is best adapted for each individual case. Of course galvano cantery is most often available but these conditions could be treated successfully without it. Ingeniously devised turtle mouthed nippers can be made to do much, as can also the cold snare, and what would remain that could not be reached by these could be destroyed by chromic acid.

Dry catarrh is very obstinate as regards cure, and this can be accomplished only in one way so far as my observation is concerned, viz. by galvano cantery. This is best done by ribbing the whole affected surface at periods of about two weeks with white heat of the electrode. After from one to

three years of occasional treatments this loathsome disease may be so far cured as to render the afflicted one ever grateful to the doctor who renders the service.

In conclusion I would say that nasal catarrh is as curable with the knowledge of to-day as any chronic disease of which I am aware. All may be benefitted and nine out of ten practically cured while over half may be quickly relieved by these surgical measures. It might be thought they would be painful but not unbearably so, as children take the treatment without crying or flinching.

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## ORGANIC CHEMISTRY

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BY PROF., M. H. LOGAN, Ph. G., M. D., SAN FRANCISCO CAL.

*Professor of Chemistry and Toxicology, in the California Medical College*

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### **Heptanes** ( $C_7H_{16}$ )

Four of the nine possible isomerides are known.

Normal Heptane  $\overline{CH_3}—(\overline{CH_2})_5—\overline{CH_3}$  occurs in petroleum and cannel coal tar. Together with octane it is the chief ingredient of commercial ligroine (or the lighter product just before kerosene) it boils at  $90^\circ$  to  $120^\circ$ . Sp. gr. at  $90^\circ$  is .6967.

### **Octanes** ( $C_8H_{18}$ )

Of the five possible isomersides two are known. Normal octane is present in petroleum, and boils at  $125^\circ$ .

The higher homologues occur in petroleum and tar oils, and cannot be isolated perfectly pure by fractional distillation.

From hexdecane onward they are all solids at ordinary temmperature and crystallize readily from alcohol and ether.

**Petroleum** or rock oil [naphtha] is produced by natural distillation in the coal beds. When crude it is a thick oily liquid with a greenish lustre. Its more volatile parts evaporate on exposure to the air; it thickens and eventually passes into asphaltum.

In the crude form petroleum has a sp. gr. of .08 to .092, and distills over from 30° to 360°

**Petroleum Ether** distills over at 50 to 60°; and is composed of pentane and hexane.

**Petroleum Benzine** [not coal tar benzine] distills at 70° to 90° and is composed of hexane and heptane.

**Kerosene** [refined petrolem] boils at from 150° to 300° Sp. gr. .078 to .082. The higher ones are lubricants.

Solar oil is the heavier oils from Saxony coal.

#### PARAFFINES. PROPER.

Hydrocarbons that boil over at above 300°

Mineral wax, called ozokerite, found free, is the same.

**Vaselines** are paraffines that liquify readily and fuse between 34° and 40°

**Petrolatum**—**Petroleum** *ointment*, formulæ chiefly  $C_{16}H_{34}$  etc. to  $C_{32}H_{34}$  etc. It is the sediment from oil tanks and residuum after distillation of coal oil.

**Cosmoline**—*Unguentum Petrolei*, formulæ  $C_{16}H_{34}$ — $C_{17}H_{36}$ — $C_{18}H_{38}$  up to  $C_{32}H_{66}$  also some olafines  $C_{16}H_{32}$ — $C_{17}H_{34}$  etc.

**Solid Paraffins** are used in making candles. Meat may be preserved by immersing in it, also lemons, limes, etc. It is used to coat paper to make it impervious to moisture, also as a lubricant. It is frequently used to adulterate chocolate and to make cheap candies and also to coat pills.

**Illuminating Gas** is composed of the following ingredients:

Acetylene  $C_2H_2$ ; Olifiant gas or Ethene  $C_2H_4$ ; Propylene  $C_3H_6$ ; Butylin  $C_4H_8$ ; Allylene  $C_3H_4$ ; Crotonylene  $C_4H_6$ ; Teren  $C_5H_8$ ; Vapor of Benzole  $C_6H_6$ ; Styrolene  $C_8H_8$ ; Napthalene  $C_{10}H_8$ ; Methyl Napthalene  $C_{11}H_{10}$ ; Fluoren  $C_{13}H_{10}$ ; Fluoranthene  $C_{15}H_{10}$ ; Propyl ( $C_3H_7$ )<sub>2</sub>; and Butyl ( $C_4H_7$ )<sub>2</sub>.

The heating and diluting gases are Hydrogen  $H_2$ —Methane  $CH_4$ —and carbonous oxide  $CO_2$ .

The impurities are carbonic dioxide  $CO_2$ ; Ammonia ( $NH_3$ )<sub>2</sub>; Cyanogen ( $CN$ )<sub>2</sub>; Methyl cyanide  $CH_3CN$ ; Sulphocyanic acid

HCNS.; Hydrogen Sulphide  $H_2S$ ; Carbon bi sulphide  $CS_2$ ; Carbon oxysulphide  $COS$ . and Nitrogen  $N_2$ .

Preparation:—Throw coal into red hot retorts and close quickly, the gas rapidly forms and is cooled in coils of iron pipe where it deposits tar, and all other constituents not gas, at ordinary temperature. It is then passed through purifiers filled with sawdust and ferric oxide moistened, which absorbs carbon dioxide  $CO_2$ —Hydrogen Sulphide  $H_2S$  etc., after which it is stored in gasometers.

Ordinary gas should burn at the rate of 5 cu. ft. per hour, and be equal to the light from 12 to 14 sperm candles.

### OLEINES.

The second homologous series  $C_nH_{2n}$  is composed of the Olefines, also called Alkylenes, beginning with Methene  $CH_2$  which is yet unisolated, and ending with  $C_{30}H_{60}$ . In their general structure two adjacent carbon atoms are united by a double affinity.

Example:— $CH_2=CH_2$   
Ethylene.

$CH_3-CH=CH_2$   
Propylene.

#### List of Normal Olefines:—

Name	Formulae	Boiling Point.
Methene or Methylene	$CH_2$	gas
Ethene or Ethylene	$C_2H_4$	"
Propene or Propylene	$C_3H_6$	"
Tetrene or Butylene	$C_4H_8$	1
Pentene or Amylene	$C_5H_{10}$	35
Hexene or Hexylene	$C_6H_{12}$	65
Heptene or $\alpha$ Enanthylene	$C_7H_{14}$	96
Octene or Caprylene	$C_8H_{16}$	120
Nonene or Nonylene	$C_9H_{18}$	140
Decene or Paramylene	$C_{10}H_{20}$	160
Dodecylene	$C_{12}H_{24}$	
Tetradeylene	$C_{14}H_{28}$	
Hexdecene or Cetene	$C_{16}H_{32}$	275
Actodecylene	$C_{18}H_{36}$	
Heptdecene or Cerotene	$C_{27}H_{54}$	57
Melene or Melissene	$C_{30}H_{60}$	62

**Methylene**— $\text{CH}_2$ , the first member of this series does not exist.

**Ethylene**— $\text{C}_2\text{H}_4$ , (Olefiant gas) forms in the day distillation of many organic substances and hence is present in illuminating gas (6 per cent.) it may be prepared by mixing 1 vol. of 80 per cent alcohol, and 6 vol. of Sulphuric acid, heat carefully upon a sand bath, purify the gas through a solution of potassium hydrate and collect over water. Ethylene is a colorless gas, with a peculiar sweet odor, water dissolves but slight quantities of it, alcohol and ether absorb about 2 volumes.

It is liquified at  $0^\circ$  and a pressure of 45 atmospheres; at ordinary pressure it boils at  $105^\circ$  hence it is suitable for the production of intense cold. It burns with a bright luminous flame, decomposing into  $\text{CH}_4$  and C. In an atmosphere of chlorine gas it burns with a very smoky flame. With 3 volumes of oxygen it forms a very explosive mixture. Aided by platinum black it will combine with  $\text{H}_2$  at ordinary temperatures, yielding  $\text{C}_2\text{H}_6$ . At the ordinary temperature it combines with sulphuric acid after violent shaking. By boiling the resulting ethylsulphuric acid with water we get alcohol.

Potassium permanganate oxidizes ethylene to oxalic and formic acids. Chromic acid oxidizes it to aldehyde.

**Propylene**— $\text{C}_3\text{H}_6$ :—This compound is obtained from many organic substances. The best method is by passing the vapor of Amyl alcohol through red hot tubes. Propylene is a gas liquifiable under great pressure.

**Butylene**— $\text{C}_4\text{H}_8$ :—This compound is interesting only from the fact of its forming what are known as isomerides. These compounds have the same impreical formulae, but differ in their graphic arrangement, as well as their properties.

**Amylenes**— $\text{C}_5\text{H}_{10}$ :—Five isomerides are possible here. The first isomeride. a amylene may be oxidized by a solution of Patassio-Manganic oxide to butyric and formic acids.

— The higher Olefines may be prepared from the correspond-

ing alcohols of the higher fatty acids.

**Hexdecene** (Hexodecylene) —  $C_{16}H_{32}$  :— commonly called cetene is obtained from cetyl alcohol. It boils at  $274^{\circ}$ .

**Heptdecene** (Heptodecylene) —  $C_{27}H_{54}$  :— also called Cerotene is derived from Chinese wax. It melts at  $58^{\circ}$ .

**Melene** —  $C_{30}H_{60}$  is derived from ordinary wax and melts at  $62^{\circ}$ .

#### ACETYLINES.

The third homologous or Acetylene series  $C_nH_{2n-2}$ .

These compounds are formed by heating the bromides of the Olefines with Alcoholic Potash.

List of the Normal Acetylenes:—

Name	Formulae	Boiling Point
Ethine or Acetylene	$C_2H_2$	—
Propine or Allylene	$C_3H_4$	—
Butine or Crotonylene	$C_4H_6$	$18.05$
Pentine or Avalerylene	$C_5H_8$	$50$
Hexine or Hexylene	$C_6H_{10}$	$80$
Diallyl	$C_6H_{10}$	$58.8+$
Heptine	$C_7H_{12}$	$107$
Octine	$C_8H_{14}$	$132.5+$
Decine or Decenylene	$C_{10}H_{18}$	$165$
Rutylene	$C_{10}H_{18}$	$150$
Pentadecine or Benylene	$C_{15}H_{28}$	$225$
Hexdecine or Cetenylene	$C_{16}H_{30}$	$280$

With Ammoniacal Solutions of the copper and silver salts, Acetylenes forms solid crystalline compounds. Hydrochloric acid will again liberate the Acetylenes. This process is used for obtaining the Acetylenes pure.

**Acetylene or Ethene** —  $C_2H_2$  :— is formed when many carbon compounds like alcohol, ether, marsh gas, methylene, etc. are exposed to intense heat (where their vapors are con-

ducted through tubes heated to redness.) It is an ingredient of illuminating gas to which it imparts a peculiar odor. The direct synthesis of Acetylene takes place when the electric spark is passed between the carbon points of a powerful battery in an atmosphere of Hydrogen. It is also produced when powdered silver, copper or zinc acts upon Iodiform.

Acetylene, is a colorless gas with a peculiar penetrating odor, it may be liquified at  $1^{\circ}$  and 48 atmospheres. It burns with a very smoky flame.

**Allylene or Propine**— $C_3H_4$ :—is formed by the action of alcoholic potash on monochlor propylene. It is very similar to Acetylene.

**Crotonylene**— $C_4H_6$  is obtained by distilling erythrone with formic acid, this is a strong smelling liquid boiling at  $18^{\circ}$ . It burns with a bright smoky flame.

The balance of this series will be treated of in another connection.

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J. B. LIPPINCOTT COMPANY will, beginning with April, issue quarterly thereafter a work entitled "International Clinics." This work will comprise the best and most practical clinical lectures on medicine, surgery, gynaecology, pediatrics, dermatology, laryngology, ophthalmology, and otology, delivered in the leading medical colleges of this country Great Britain and Canada. These lectures have been reported by competent medical stenographers and thoroughly revised by the professors and lectures themselves. The object of the work is to furnish the busy practitioner and medical student with the best and most practical clinical instruction, in concise form. Each volume will consist of over 350 octavo pages, illustrated with photographic reproductions of important cases.

## NOTES BY THE WAYSIDE.

BY H. T. WEBSTER, M. D., OAKLAND, CAL.

*Professor of the Principles of Medicine, and Pathology in the California Medical College.*

THE prolonged prostration following the epidemic influenza of the two seasons past is an occasion of frequent remark. The antipyrine fashion of the past year or two and the well-known effects of this agent in producing feeble heart action suggest the possibility that this drug may have been a factor in the numerous cases of death from heart failure reported. I know of a number of cases where feeble action of the heart has been a persistent sequel of la grippe in which the subjects have formerly been frequent users of antipyrine for headache. However this may be, a prompt and efficient heart tonic seems demanded in nearly all cases convalescing from the present epidemic. This is represented by cereus Bonplandii, which has afforded me good satisfaction in numerous cases. In some instances there is so much giving way of the nervous energies that phosphorus becomes a good remedy to permanently improve the innervation of the heart as well as other parts of the general system.

The following "hint to writers" from the *Cleveland Medical Gazette* is very pertinent. A few of the writers of the day need to heed it, for they *will* strain at the gnat of pedantry; whether they swallow the camel of the metric system straight is another question. Few know and fewer care:

Writers for medical publications, when they have occasion to use weights or measures, should use the ordinary method if they desire to be read and understood by the majority of American physicians. If they prefer the metric system, the ordinary equivalent should be appended. Whatever the future may do toward supplanting the old-fashioned English weights and measures and establishing the metric system, that time has not yet arrived when the latter is preferred and familiarized by the majority. A book or journal article besprinkled with the foreign-looking and unfamiliar terms of the French system is generally skipped by the average reader, or if read it conveys but indefinite and unsatisfactory knowledge.

But it does convey one or more of four impressions: First, that the writer is pedantic; second, that he wants to be a reformer; or third, that he wants the reader to know that he has been abroad; or, fourthly, that he does not care to be read by the rank and file of the profession.

Two more cases of genuine diphtheria have enabled me to give the new drug, echinacea, further trial, and to observe its action and form some conclusions as to its proper place. We must be careful not to form an exaggerated estimate of any new remedy, but learn to adapt it to its proper sphere. Of the two cases mentioned one recovered and one died. The case which recovered presented the *putrid* symptoms much more prominently than the fatal one—here the cause of death was plastic exudation blocking up the respiratory passages. In the last which was the fatal case (both being in one family) echinacea was begun several days before any symptoms of the disease appeared. However, the case which recovered had the advantage of age, the patient being seven years old, while the one which died was a trifle less than two. I propose to assert that echinacea is the remedy for putridity—septic tendency with disposition to breaking down of tissue, but not for the condition where plastic exudation is a prominent feature of the disease. These two conditions hardly go together. Differentiation must be borne in mind constantly if we succeed in adapting remedies to disease. I doubt if we have any other remedy equal to potassium chloride as prescribed by Schussler in plastic exudation.

I HAVE been much interested for a time past in the perusal of Prof. Howe's new work "Operative Gynecology." The book might be criticised like most first editions, but as the faults consist largely of typographical errors and minor grammatical inconsistencies, it is probable that the author has seen these and knows of them himself better than any reviewer could and they will all probably have disappeared in a revised edition. The work is a condensation of valuable knowledge which we have needed in our school for

years; for, giving other works on Diseases of Women their just due (I have never seen Professor Clark's work), the surgical element was lacking, and as Prof. Howe has stood at the front of surgical men in our school for the past several decades, it is meet that he should have written this treatise. Every Eclectic who has any future before him should have the book for study and reference.

I am not favorably impressed with the manner in which some important points have been disposed of, however. My experience as regards the advantages of amputation over trachelorrhaphy in lacerated uterine cervix is entirely contrary to the statements here, which however of course has been small beside that of Prof. Howe. He describes the most difficult plan of operation for trachelorrhaphy and one which will soon become obsolete. The operation of the French—patient on her back with perineal retractor in place allows the cervix to drop into the vulvar opening where the operation is easily done—a curved needle with a firmly attached handle being employed to draw the sutures in, without the putting with Emmet's short needles. This is a very simple plan beside the difficult one described in this work. The operation for laceration of the prineum is also antiquated and our author has added to its cruelty by supplementing two deep provisional sutures which must increase the horrors of the eight or ten days of suffering such an operation will entail. I do not say that procedures described here are not orthodox, but I do assert that a patient must be saturated with opiates for eight or ten days after such an operation to make life endurable, and afterward break off an opium habit, while the proper operation will reduce the chances of suffering to such a minimum that there is little more pain than that following a trachelorrhaphy. But so long as the author is an ardent devotee of such olden time authorities as Holmes' System of Surgery we must expect an adherence to many of the older customs.

However the author is original in many respects and offers us not only a thorough detail of the technique of this sub-

ject as ordinarily understood, but adds to it much of his own creation, making the work indispensable to all our men who aspire to surgical gynecology.

In a letter recently received from Professor J. U. Lloyd the following reference to my work on Principles of Medicine occurs:—

“I am glad to observe that you use the word “Specific Medicines” throughout your book instead of “Specific Tinctures.” The word tincture is misleading and is only a misnomer as applied to the medicines that have attained the popularity and reputation that our Specific Medicines have. Besides, when the word Specific Tincture is used, in many instances substitutions are made of common tinctures that would not be done if the doctor would use instead the term Specific Medicine. He uses the medicine for a specific purpose and he cares little whether it is a tincture or a pharmaceutical compound, provided it is the remedy that has given the satisfaction. You see the point. Then again, many of these substances are not tinctures at all. As, for example, phosphate of soda, sulphite of soda, solution acetate of iron and so on, so that you will see in order to be consistent you should use the term Specific Medicine which you have abbreviated to s. m. very properly.

“Concerning the point you make on page 159 concerning pulsatilla, I will say that the preparation of pulsatilla made in Germany and sold under the name “German Pulsatilla Tincture” is one of the most unreliable preparations that I have ever seen. My experience is that the imported German tinctures are as a rule frauds when it comes to reliability and some of the most outrageous substances with which I have met have come to us direct from Germany under the name German tincture and this is true of pulsatilla. Some years ago we imported some thirty or forty gallons of German Tincture Drosera and in each can there was sediment covering about one eighth the depth of the liquor. The balance of it was like thin tar. We could not convince ourselves that it was drosera at all. This is true of other prep-

arations. In my opinion, they send to America the refuse of Germany. At least it seems as though they do. Concerning pulsatilla to which you refer specially, I will say that the only method that we can use is to have the herb gathered green, packed into barrels while it is green, enough alcohol put on it to preserve it and shipped to us in barrels. Then we make our preparation from the green herb, which is the kind (our make) that is used throughout America. The order is already in for next year's pulsatilla for our use. I call this to your attention because I see that you have every confidence in Specific Pulsatilla as made by us, while the substances that are sold under the name German Tincture I presume you have scarcely ever used at all or seen. At least if you have used them they certainly will have given you little satisfaction."

QUITE a number of good words for "Principles of Medicine" have been received from various private sources. Dr. Kent O. Foltz of Akron, Ohio writes: "This office is of the opinion that it is one of the best books ever published on Eclectic Medicine." Dr. J. W. Payne of San Diego Cal. writes: your "Principles of Medicines received. I have examined it with considerable care and am very much pleased with it. It is compact, exact, up to the date and very instructive. It is certainly as well arranged and as useful a volume as can be found on the subject. It is in language style and arrangement so much like the author that it almost carries with it the sound of his voice and the expression of his face. I will have occasion to refer to it often."

Dr. G. A. Rowe of Buffalo, N. Y. writes: "After having looked it over carefully I am pleased to say that it is an excellent production. It shows much originality of thought, and while in perfect harmony with all Eclectic teachings, yet it points out a large field in therapeutics that has not been thoroughly explored. The book will prove indispensable to students and should be possessed by every progressive Eclectic in the country.

## COLLE'S FRACTURE.

BY W. B. CHURCH, M. D.

*Professor of the Practice of Medicine in California Medical College.*

If an apology is needed for occupying your time and attention with so common and trite a subject as fracture of the lower end of the radius it may be found in the fact that a majority of those who have suffered this tension are permanently deformed and, to some extent, disabled. Further justification for urging better methods might well be based on the fact that as ordinarily managed the suffering is greatly in excess of what it should be, and the period of disability and convalescence prolonged unnecessarily, occupying at least, as many months as it should weeks. The importance of the question is apparent too, in the fact, that this fracture is of more frequent occurrence than any other, with bad results the rule, as already intimated.

Many surgeons and even reputable surgical authors concede that only partial restoration is possible in many cases.

It has been too much the custom with the rank and file of the profession to refer their complaining patrons to these authorities to allay as far as possible their discontent on account of their severe suffering and especially the stiffness, sensitiveness, and disability which continued so troublesome for months after the dressing was removed.

A surgical writer, held in deservedly high repute among Eclectics, says: "The deformities following Colles' fracture present unmistakable characteristics, whether treated well or ill, or not treated at all." With all deference to one high in authority this statement is believed to give too much latitude and warrant for careless surgery. It should be so modified as to state that no deformity follows in well treated cases, and that in only in very exceptional instances need there remain permanently any deformity or disability.

It must at the same time be admitted that the treatment, as ordinarily applied, by the great majority of surgeons, presents no advantages in any respect over no treatment at all. Indeed, suffering and deformity are often aggravated beyond what would be experienced if left entirely without treatment.

The same writer already quoted says, "In elderly people some degree of ankylosis and stiffness in the wrist and fingers, lasts for weeks, months and even years."

Erickson and many other authors make similar statements. Such unpleasant consequences are indeed experiences. That they are unavoidable is by no means conceded.

In order to treat this most common of all fractures successfully, and avoid so much that is painful and unsatisfactory during the treatment, and escape the prolonged and painful convalescence, it is necessary to get a clear idea of the mechanism and precise nature of the injury. When these are fully understood, it will be seen that we have a lesion which offers a better prospect for perfect restoration than most varieties of fractures; that there is no good reason why our cases of Colles' fracture should not recover as promptly, with as little pain, and resulting deformity, and as rapid and painless convalescence, as other fractures. It is produced, as you all know, by extending the hands when falling forward, instinctively preferring to take the unavoidable contact with the hands rather than the head or face. Not to go into further details, it is sufficient for our present purpose to say that the violence of the contact produces fracture of the radius, at a point varying from half an inch to an inch above the carpal articulation. The line of the fracture is nearly transverse. The degree of displacement depends upon the momentum acquired in the fall; if this is barely sufficient to fracture, the displacement may be slight. Usually there is a considerable degree of additional force acquired, and its expenditure causes displacement and deformity, with shortening of the forearm. The posterior bor-

der of the upper fragment is driven into the anterior border of the lower, either splitting it or tilting it upward and backward. The ulna is detached from its radio-carpal connection, and its distal extremity is driven downwards and forwards along the outer aspect of the cunoid bone. This displacement of the ulnar extremity is too often ignored in treatment; if not remedied it will be the direct cause of severe pain and inflammation, which will be responsible for the subsequent ankylosis and sensitiveness so often complained of. The restoration of the styloid process of the ulna to its proper position, and observing that it remains there after the extending forces are relaxed, is an excellent test of the success of your efforts to reduce the fracture. This is indeed the most important landmark from which to determine the necessity for further manipulation, and we are never to rest satisfied with our efforts until it is properly located and shows no disposition to change.

There are two methods of reduction either of which may be chosen. In one the hand is forcibly extended to the position it occupied when the fracture occurred; this has the effort to unlock the lower fragment, their under extension and counter extension, the hand is brought into line with the forearm, while the operator's thumbs press the lower fragment into position. If this restores the contour of the forearm, and it persists after the extending forces are relaxed, it only remains to apply a light simple dressing that will retain and support the parts until union takes place, which will be in three to four weeks.

Another method, equally easy of application, and just as successful, is to flex the hand upon the forearm over the operator's knee, and under extension and counter extension drag the lower fragment into place by pulling on the hand, and then, without relaxing the extending forces, bring the hand into a straight position. If, left now to itself, there is any disposition to recurrence of the characteristic silver-fork deformity, the manipulation is repeated; but when the natural contour of the forearm is restored and persists, and

the styloid process, of the ulna is seen to be in its proper position, pain will be much relieved, and the dressing may be applied. Many devices for supplementing imperfect attempts at reduction have been resorted to, but they have all failed miserably. Prominent among these is the pistol shaped splint, into which many an arm, with fracture unreduced, has been forced to lie for weeks, in intolerable pain, which continued for weeks months, and years, after it was released. The all important thing is the complete restoration of the fragments, the accurate adjustment as above described; this having been secured the dressing is a matter of secondary importance; any light material that will secure inability. There will be only little pain. The dressing should extend from the elbow over the metacarpus leaving the fingers and thumb free, it should be left on about three weeks with children and four weeks in cases of adults.

Very rarely, in falling from a height, or being hurled with great force in a railroad accident, the lower fragment may be so comminuted that no fragment of it will remain of sufficient bulk to counteract the contraction of the muscles of the forearm. In these cases it will be difficult and may sometimes be impossible to secure perfect results; but in the vast majority of cases to do so is inexcusable, and the great number of crooked, deformed, weakened arms, in the community, is an approbrium to surgery.

## SELECTIONS.

## PÆDIATRIC THERAPEUTICS.

## INHALATION FOR WHOOPING-COUGH.

Beall recommends the following formula:

R.	Thymol,	gr. xx
	Acid carbolic,	
	Ol. sassafras,	
	Ol. eucalypti,	
	Reis liquidæ,	
	Ol. terebinthinæ,	
	Ætheris,	f 3 iv.
	Alcoholis, q. s., ad.	f 3 iij. M.

S. Put about thirty drops upon a pad of such size as to be conveniently hung around the child's neck, renewing the application every two or three hours.—*Daniel's Med. Jour.*, 1890.

In severe cases the inhalation treatment is supplemented by the internal administration of

R.	Acid carbolic,	gr. iij.
	Sodii rbomid.,	gr. i.
	Tr. belladonnæ,	gtt. xx.
	Glycerin.,	f 3 iij.
	Aquæ, q. s., ad.	f 3 iij. M.

S. 3 i for a child 3 or 4 years old, occasionally.

## WARTS.

R.	Hydrarg. chlor. corros.,	1 part.
	Collodion,	30 parts. M.
S.	Apply once daily about the base of the wart.—	

*Cincinnati Lancet-Clinic, February 21, 1891.*

## A PLEASANT VEHICLE FOR CASTOR OIL.

The following mixture is recommended as an efficient means of disguising the taste of castor oil. The only disadvantage is its bulk in proportion to the dose of oil administered.

R	Castor oil,	30 parts.
	Bitter almonds,	2 "
	Sugar,	30 "
	Gum tragacanth,	$\frac{1}{2}$ "
	Orange flower water,	10 "
	Water,	120 " M.

—*American Druggist, January 15, 1891.*

#### SEDATIVE FOR BABIES.

Dr. Van Goidtsnoven, of Atlanta, gives a formula with which he has had most gratifying results in restlessness, spasms, deliria, and in all cases requiring a sedative, anodyne, anti-spasmodic or somnifacient.

R	Camphor, monobromat.,	gr. xvi.
	Ext. hyoscyami fl.,	gtt. xvi-xxx.
	Syrup lactucarii (Aubergier's),	f $\frac{3}{4}$ viij. M.

S. A tablespoonful every hour till relieved.—*Dixie Doctor, 1890.*

#### INFANTILE CONSTIPATION.

Bouchut employs the following syrup:

R	Podophyllin,	gr. i.
	Alcohol,	f $\frac{3}{4}$ iss.
	Syrup althæa,	f $\frac{3}{4}$ iv. M.

S. Dessertspoonful daily.—*Union Medicale, 1890.*

#### CREOLIN IN ACUTE GASTRO-ENTERITIS.

Schwinz has employed this drug with success in the following formula:

R	Creolin,	gtt iij.
	Syrup althæa,	f $\frac{3}{4}$ v.
	Aq. cinnamonii, q. s., ad.	f $\frac{3}{4}$ iij. M.

S. To a very young child a small teaspoonful hourly. To older children the drug may be given in a powder.

R	Creolin,	gtt. xv.
	Sacchari alb.,	gr. lxxv. M.

Divide in Chart No. X.

S. One or two powders daily.—*Wiener Medizinische Wochenschrift, No. 3, 1891.*



## CROUP.

J. B. Johnson uses the following:

R.	Aquæ destillat.,	f $\mathfrak{Z}$ i.
	Potass chlorat.,	
	Potass iodid..	aa $\mathfrak{Z}$ i.
	Emuls. arabicæ,	$\mathfrak{Z}$ ij,
	Mucilag. acaciæ,	
	Ext. ipecac., fl.,	
	Olei capaibæ,	aa $\mathfrak{Z}$ i. M.

S. Shake well. Dose, a teaspoonful every ten minutes, to an infant of 8 months, till free vomiting ensues; and then continue the same dose every half hour or hour until the disease is cured. The dose must be given according to the age of the child.—*New England Med. Monthly*, 1891.

## Injuries Due to Coition.

Some two years ago I performed a plastic operation on the anterior wall of the vagina for a poor woman who was living in one of our small courts, and closed the wound with shotted silkworm gut. Toward the end of the week following the operation, the husband returning home one night in a drunken condition, insisted upon and had connection with his wife. The fact was concealed from me and I only discovered it some days later, when I came to remove the stitches. I then found that most of the sutures had been torn out and the wound considerably enlarged. The whole denuded surface was in a condition of suppuration and was treated as an open wound, healing by granulation and leaving some ugly cicatrices. I examined the husband's penis and had the extreme pleasure of finding it in a condition better imagined than described.

Once before this I found some sutures torn out from a perinæum which I had repaired, in such a manner as to excite my suspicion that coition had taken place. The behavior of both husband and wife, when questioned on the subject, was convincing that such had been the case. Fortunately, the act had occurred some two weeks or more after the operation, and union being fairly firm, not much damage was done.

Incidentally, I may say, a few years ago I discovered that the husband of one my patients, on whom I had performed an abdominal section for double gonorrhœal pyosalpinx, had, the night previous, had connection with his wife. This happened in spite of the fact that there was a nurse in attendance and the glass drainage tube was yet in place. In spite of this the woman recovered.

In truth, so many accidents and anxieties have I met with from time to time, that I have become convinced that gynaecological surgery, at least in our back alleys, is no sinecure.

A few months ago I was called to see a woman who was suffering from haemorrhage. The bleeding had ceased, and I was called to attend her because coition was well-nigh impossible, on account of the pain it caused. An examination disclosed a recently-ruptured hymen, with several lacerations of the m. m. of the vagina. Immediately in front of the base of the hymen the m. m. was denuded of an irregular piece about the size of a silver dime. One of the lacerations in the vagina ran in the direction of the right sulcus, presenting a deep, gaping wound about an inch in length. The woman had only been married a few days before and her trouble began with the first coition. I trimmed the remnants of the thickened hymen away and brought the edges of the right lateral laceration together with a few sutures. The woman returned to her husband in the course of three or four weeks and had no subsequent trouble.

Such accidents as these are by no means uncommon, but in looking over the literature for the past year or two, I have been surprised to find the number and extent of injuries which may follow coition.

Spaeth (*Amer. Jour. of Obstet.*, September, 1890) reports three cases of injury from coition. Case I. The patient was 31 years old. During the first two days after marriage she had moderate pain with coition and insignificant bleeding thereafter; but on the 31st of January she experienced excessive pain during intercourse, and had the sensation as if the penis was forcing a wrong passage. Copious bleeding followed. Three days later flatus escaped from the vagina, and on the fourth day faeces. On examination the somewhat thickened columna rugarum posterior was found torn away from its attachments to the perinæum. When lifted up by a tenaeulum, a vaulted opening with smooth edges, and about the size of the little finger, was observed, from which faecal masses protruded. It led to the rectum, as shown by a catheter introduced from the anus. The anterior rectal wall was perforated to about the breadth of two fingers. Case II was 28 years old. She had undergone a severe instrumental labor, resulting in complete tear of the perinæum deeply into the rectum. An operation was followed by uninterrupted healing. During the third night after her discharge she had a profuse haemorrhage. The next morning the doctor, on removing the tampon which he had temporarily placed in the vagina the night before, discovered a fresh haemorrhage from a tear in the vagina about 3 cm. wide, running transversely in the posterior wall at the site of its merging into the portio vag-

inalis; arterial bleeding at one angle of the wound. She at first denied having copulated, but later acknowledged it. Case III was 28 years old. Her first labor followed by a total perineal rupture. A successful operation for the repair of the injury was performed. Several days after leaving the hospital a severe haemorrhage took place. There was a transverse tear in the vagina at the posterior vault. The cause of the accident was proved to have been forbidden coition. It is remarkable that in both these last cases the freshly-united tissues did not give way, but the vaginal vault ruptured both times.

Hofmokl (*Internat. Klin. Rundschau Wien.*, September 28, 1890) tells us that in the last four years, in Vienna and Prague, there have been four cases of injury to the vagina following coition. Case I was a woman 58 years old. The injury occurred in the vault of the vagina. Case II was 26 years old, and the laceration occupied the posterior part of the vaginal vault. Case III was 71 years old. The laceration was in the m. m. of the vaginal vault, and was followed by severe haemorrhage. Case IV occurred in a woman 18 years old. The injury was a laceration of the m. m. of the entrance of the vagina. The genital track was imperfectly developed. In all these cases there was profuse haemorrhage with painful coition.

Smolitcheff (*Annals of Surgery*, October, 1890) reports the case of a lady, 31 years of age, who applied to him on account of sacral and rectal pain and discharge of blood and faces from the genitals, which symptoms had made their appearance during her first coition with her husband twelve days previously. On examination the labiæ major were found swollen and tender. the vaginal inlet totally closed, with a red, unyielding, fleshy membrane, the posterior commissure ruptured, the wounds filled with blood and faeces. A forefinger pushed into the wound easily penetrated into the rectum at the depth of 7 cm. The said fleshy membrane proved to be an abnormally developed hymen with a median linear, raphe-like groove and a minute orifice situated close to the urinary meatus.

Doolittle (*Canad. Pract.*, May, 1890) relates the case of a young couple who had been married clandestinely. They came back to the house of the bride's mother and were together for about half an hour, when the bridegroom left. In the morning the doctor was sent for and found the girl blanched and with all the signs of a great loss of blood. On examination he found the vagina filled with clots. On clearing these away the hymen was found to be torn out to the depth of an eighth of an inch; at the bottom of the tear there spurted forth a small artery, from which the haemorrhage had occurred.

Sargent (*West. Med. and Surg. Rept.*, November, 1890) was called

to see a woman, 26 years of age, whose youngest child was 5 months old. She was suffering from a profuse haemorrhage. A complete rent in the posterior portion of the vagina about two and a half inches in length was found. Both the woman and the husband stated that the bleeding began immediately after copulation.

Sinalsky (*Annals of Surgery*, Nay, 1890) reports the case of a newly married woman, 23 years old. She stated that the first and only coition had given rise to excruciating local pain and profuse bleeding causing her to faint. An examination showed that the hymen was intact. The posterior commissure proved to be lacerated, the wound forming a funnel-shaped cavity, admitting freely two or three fingers and communicating with the rectum just above the anal sphincter; the vagina contained faecal gases and matter. There was also a total rupture of the perineum, running along the raphe, but involving only the skin and subcutaneous cellular tissues. In addition to the cases I have already given, Sinalsky quotes a large number. Albert's case (*Hoffman's Handbook of Forensic Medicine*), of an Arabian girl, aged 11 years, in whom the first intercourse caused the rupture of the posterior commissure, navicular fossa and vaginal fornix, the latter communicating with the abdominal cavity. Tolmouche's (*ibid*) case of rupture of the perineum in a ravished girl, aged 25 years. Zeiss's (*Cent. f. Gyn.*, No. 8, 1886) case of laceration of the vaginal roof during coition performed in an elbow-knee posture about six weeks after a forceps labor. Chadwick's (*Boston Med. and Surg. Jour.*, April 30, 1885) case of the rupture of the vagina in a sterile woman, aged 48 years. Masalitinoff's (*Lond. Med. Rec.*, May, 1886) case of rupture of the perineum in a woman, aged 24 years, the lesion taking place during her first coition with her athletic husband, who performed the act in a drunken state. Also, his second case of vesico-vaginal fistula, occurring in a Georgian woman, aged 18 years, during her first coition with her husband. Boiakovsky's (*Vratch.*, Nos. 46 and 47, 1886) case of rupture of the perineum and vulvo-rectal fistula in a peasant woman, aged 17 years. Esipoff's (*Lond. Med. Rec.*, May, 1886) case of rupture of the urethra occurring during the first coition in a young woman aged 19 years, with imperforate hymen, and 2,000 c.cm of blood pent up in the vagina and womb. Price's (*Amer. Obst. Gaz.*, Nay, 1886) case of vulvo-rectal fistula, arising during the first coition in a woman aged 22 years. Duguer's (*Vratch.*, No. 47, 1886) case of rupture of the perineum and vagina during the first intercourse with the husband. Blumenthal's case of vulvo-rectal fistula. Diernerbroeck's cases (*Anatomic. Corporis Humani*) of rupture of the vagina occurring in two newly married Dutch women, both of whom died from acute anaemia caused by hemorrhage; and finally, Liman's case (*Hoffmau's Hand-*

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*book*) of rupture of the perinaeum.

Little comment is necessary upon such a record as this. There does not seem to have been any real cause for these injuries, as far as the tissues of the women themselves were concerned. In no case is it recorded that there was undue rigidity and friability. In a few cases the hymen was thickened, but this would have rather tended to prevent some of the lacerations than otherwise. The accidents for the most part occurred during the first coition, and were accompanied necessarily with great pain to the women, and also, it is to be hoped, to the men. There seems to be no reasonable doubt that in a certain proportion of cases the fault lay in the brutal instincts of the men, often too drunk to realize or care what mischief they were doing. In other cases the cause was no doubt ignorant, but, nevertheless, brutal, ill-directed attempts at coition. The immediate results of such accidents are great pain and hemorrhage. Many of the women were permanently crippled, and several lost their lives as a result of their injuries.—*Dr. J. M. Baldy, in Annals of Gynaecology.*

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## THE TREATMENT OF MASTITIS BY REST AND PRESSURE.

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BY DR. W. F. MILROY, OMAHA, NEB.

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Abstract of a Paper read before the Medical Society of the Missouri Valley.

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The design of the paper was to bring to the attention of the society a plan of treatment set forth in a paper published five years ago in the *Medical Record*, and to emphasize its value as illustrated by further experience.

The importance of attention to the subject was referred to, owing to its frequency and the imperfections of older methods of treatment, together with the serious consequences which attend the disorder.

Anatomically, there are three varieties of mastitis, viz, subcutaneous, glandular and sub-glandular. Of the glandular form, a sthenic and an asthenic type appears.

The plan of treatment in question has to do with the sthenic type of the glandular variety only. This was shown to be a very frequent form of the disease.

The method was described as follows:

A piece of strong muslin is used, fourteen to sixteen inches in width, and of a length sufficient to reach around the thorax of the patient and overlap a few inches. The patient lies upon her back, with the arms elevated to clasp the hands above the head, thus:

drawing the axillæ well upward. One end of the muslin is slipped through beneath the patient, and the two ends made to overlap exactly as in the application of an abdominal binder. A pad of cotton wadding is placed between the breasts to serve as counter-pressure. The breasts are then pressed upward and toward the sternum by an assistant, and the muslin is fastened by pins, which are placed along the middle line about three-fourths of an inch apart. As the pins are put in place, the bandage is drawn tense by about all the force one can comfortably exert through his arms.

□ When the bandage has been fastened, proceeding in this way from above downward, it will usually be found that its upper part is comparatively loose, and a few pins should be removed and re-applied. The bandage should be brought well up against the axillæ, and thus the upper part of the breast will be included within it. When it is in place, a small wad of cotton should be tucked in beneath the folds of the axilla above the bandage. This will relieve all feeling of irritation from the bandage in that location. A small hole should then be cut with a scissors over the nipple of the sound side, and the child allowed to nurse this breast. The one principle to be borne in mind in the application of this bandage is to make sure that every part of the breast is included in it, and that the pressure is even throughout. With reasonable care this is easily accomplished. In case the trouble occurs long enough after confinement, so that the patient is out of bed, a strap of muslin may be passed over each shoulder and pinned to the upper edge of the bandage, before and behind. This will overcome any tendency toward slipping down. If the patient is in bed this is wholly unnecessary. The bandage having been once applied need not be removed until the unpleasant symptoms are entirely gone, but may be tightened above and below, as the diminishing size of the breast will permit. After all tenderness is gone, having removed the bandage, the breast appears greatly reduced in size, the integument is relaxed in small wrinkles and folds, and no sign of inflammation is present. There is, however, a uniform induration over the entire organ, it being in a condition somewhat analogous to that of hepatized lung-tissue due to pleuritic effusion. From this it recovers in a few hours if the child be reapplyed to the breast, and in a little longer time if the breast be allowed to remain inactive. I would emphasize the necessity for all parts of the breasts being subjected to pressure, for if this be not done, signs of inflammation will very soon appear in the part not compressed.

Incredible as it might seem to one who had given the matter no attention, that such pressure as has been described can be endured by a patient with a breast engorged, indurated, red and exquisitely sensitive, it is, nevertheless true. The cause of pain is pressure

from within, due to the engorgement. Counter pressure between the bandage and the chest wall overcomes the distension, and the pain immediately disappears, provided the pressure be evenly applied.

In the early part of any inflammation there is a dilation of the capillaries and small arteries of the whole neighborhood, which in this case is added to a physiological congestion of the gland. Now, owing to the anatomical structure of the parts, it is possible to so apply pressure that simply by mechanical force the engorgement with blood and with milk is very greatly diminished in the gland and *pro rata* the inflammatory symptoms. This is found to be the case clinically as well as theoretically.

A number of writers have advocated rest with support of the breast. The author insists upon firm pressure as differing in its essential nature from simple support, and giving far better results.

The treatment by rubbing out the breast was unfavorably compared with that by rest and pressure.

First, because it is difficult to secure its proper performance, while the bandage is applied by the physician and does not require special skill.

Secondly, because it wears out patient and nurse, while the bandage gives comfort and permits rest.

Thirdly, because it is untidy, while the bandage is clean.

Fourthly, because it sometimes fails while the bandage in suitable cases and properly applied always succeeds; and

Fifthly, because it is irrational and unscientific in that while lacteal engorgement is admittedly a potent cause of this trouble, it is promoted by the rubbing, but the use of the bandage is based upon scientific principles and aims directly at the root of the evil.

Other advantages, such as the opportunity for the healing of sore nipples and the suppression of the milk in case of death of the infants were alluded to, and a severe case cited by way of illustration.—*Weekly Med. Review*.

WE notice in an eclectic medical journal that the hospital of Springfield, Ohio is to be under the administration, during alternate years, of the regular physicians and of the eclectic physicians of that city, that the two modes of practice may be observed and compared. We heartily approve of this, as we think the absolute truth can be better brought out by this means than by all the discussion in the universe. We believe that there is much merit in both methods of practice, and that they are yearly coming closer and closer together by the influence of sensible men of each system, who are selecting the best out of the other, until, finally, there will be no difference at all—nor will there be any distinctive title other than physician or doctor.—*THE MEDICAL WORLD*.

## IMMEDIATE REPAIR OF THE PERINEUM.

In a paper read before the New York Academy of Medicine (*N. Y. Med. Jour.*) Dr. T. H. Hance advocated the immediate repair of injuries to the pelvic floor, where the laceration had not extended through into the rectum, that is in cases where there was either a clean cut through the perineum to one side or other of the median line. In these cases where the posterior vaginal wall had been ruptured without laceration of the skin, the operation also offered good results. He thinks that there ought to be no difficulty in recognizing these incomplete lacerations at or just before delivery (by digital examination) thus gaining time to make preparations to repair them at once. He introduces the first suture high up in the vagina above the tear, in order to avoid the formation of pockets; he also thinks that this method offers the best results for the restoration of the pelvic floor. If the laceration has extended up on both sides, they are to be repaired separately. The patient's legs are kept tied together for 24 hours after the operation, and the bowels are moved on the third day. He says that two points ought to be closely observed in order to insure success, that is the careful adaption of the lips of the wound, numbering the sutures to individual requirements; and secondly, the observance of strict antiseptic precautions, including the use of antiseptic douches before and after the operation, antiseptic pad, etc.

All members taking part in the discussion expressed themselves as in favor of the immediate operation.

MEDICAL WORLD.

## THE URINE IN CHILDREN'S DISEASES.

"M. P. BINET, writing in the *Revue medicale* on the Urology of Children, states that albuminuria is the rule in febrile infectious diseases, only slight traces existinig in the majorityof cases. It is generally most severe in diphtheria, independently of the necessary correlation with the fever and the gravity of the disease. The detection of peptonuria is subject to error. Peptonuria is not very common in children, at any rate in appreciable quantity. It usually coexists with albuminuria, and is most frequently observed in diphtheria, especially in the graver forms and in nephritis. Diaceturia is common in infectious diseses, and especially in scarlatina. It is exceptional insimple uncomplicated diphtheria."—*Lancet*.

## EDITORIAL.

PASTE IN YOUR HAT.

Ayes—Baily, Banks, Britt, Byrnes, Campbell of Siskiyou, Carpenter, Dargie, Dennison, Everett, Flint, Goncher, Hamill, Harp, Maher, Preston, Seawell, Simpson, Sprague, Streeter, Welch, W. H. Williams, G. H. Williams.

Nays—Campbell of Solano, Dray, Fraser, Heacock, Mahoney, McComas, McGowan, Ostrom, Shippie.

This note on the Medical bill in the Senate should not be forgotten by homœopaths or eclectics. They may have their day of retaliation. Some of these men who voted in the affirmative may desire to *misrepresent* their constituents at some future period; and we honestly confess that we are so deficient in Christian charity, after being smitten on one one cheek, we would not turn the other, but strike back with all our might.

This matter has taught us a lesson, which we should not forget. It has taught us, if we desire justice, we must strike as a political organization, irrespective of present party affiliations. We have a power that can be felt by politicians if we only use it to our own advantage. And use it we must at the next election.

A combination of Homœopaths and Eclectics can, through their influence control sufficient votes to elect or defeat any candidate for a state office, whom they choose. It is time the combination was formed. We should be in a position to say to a candidate for governor, if you do not give us a fair representation in the medical appointive offices of the state, we will elect your opponent who will. The same tactics would give us our just rights in almost every county in the state.

It is time we threw aside our modesty and demanded our rights. It is more than taxation without representation—it is an outrage beyond endurance, which should no longer be tolerated—that one school of medicine should monopolize the state and city branches of health and arrogate to itself all medical wisdom as if by divine right. A change will come if we only unite. Are you ready? Give us your opinion on the question.

In cases where patients have been on a protracted spree, and is threatened with the tremens or already have it. Bro-midia is the remedy, given in sufficient quantities to keep the sufferer perfectly quiet, its effects are equaled by no other medicine. This remedy controls the nervous excitement, and to supply the lack of the stimulants, which I always withdraw at once, I give the following:

R.	Tr. Capsicum	ʒ ii—iiij
	Tr. Ginger	ʒ iiij—iv
	Con Tr. Avena Satvi	ʒ j.
	Com Tr. Cuichonia qs. ft.	ʒ iv

M et S

One teaspoonful every two hours.

FOR the dry tongue and burning in stomach, I order powdered elm bark stirred in a tumbler of water, sometimes adding ice, till a thick mucilage is formed and give freely; in fact all that the patient will drink. It proves very cooling and soothing to the tortured mucous surfaces. For diet I allow the most bland: milk being the best, and when the tongue is red, which is nearly always the case, buttermilk will be much relished and prove very satisfactory. V.

In La grippe, I give the following.

R.	Gelsemin	grs. j—jss
	Macrotin	grs. v—x
	Antifebrin	grs. xxx—xl
	Quinine	grs. xxx—xl

M et fill Cap no x

S. One every three hours.

I have treated more than one hundred cases with the above prescription, without a death or being followed by pneumonia, while they have died all around me under the treatment of other physicians.

Of course the dosage depended on constitution and condition of each individual case. occassionally some other medicine was prescribed, but chief reliance was placed on the formula given. I know I lay myself open to criticism as

a "routinist," which I admit, as far as the treatment of the *grippe*. But I feel that the *result* justified the *means*. Some persons are exceedingly susceptible to the effects of gelsemin, and much care must be used in its administration. Macrotin here displays its specific action, to good effect, in controlling the aching of the head, back and limbs, and the muscular soreness.

V.

To wash out the bladder I use a soft catheter and a very small funnel, about the size of an ordinary sewing machine oil can, which of itself answers a good purpose, by removing the bottom.

I have the patient get everything in readiness, so he will not have to move to get anything. Next I show him how to introduce the catheter, letting the outflow of urine be the guide as to when the end is in the bladder. Then having slipped the small end of the funnel into the end of the catheter, he holds it at the proper elevation with the left hand, while with the right hand he pours out of a small pitcher the medicated fluid to be used in the irrigation. When the bladder has been filled to the point of uneasiness, or causing a desire to urinate, the hand is lowered, without withdrawing the catheter, and the bladder is soon emptied, when it may be again refilled. This may be repeated as often as desired.

This will be found a convenient and inexpensive apparatus, one that can be safely used by any patient with ordinary intelligence. This treatment is especially efficacious, in the cystitis of women. And being so simple and inexpensive, it places at the disposal of the physician a valuable aid, however poor or remote from town his patient may be. V.

DR. CORNWALL reports his hospital project is satisfactory to himself and his associate Dr. Hunsaker. At the present there are six patients in the house, and a number have been discharged with gratifying results compared to those when his patients were scattered over the city in private houses, hotels, etc. Any physician in the city may have his patients cared for here, providing the surgical operations are small, and there be no infectiousness about the diseases.

DYSENTERY:—Summer will soon be upon us and as the days get long and hot, we will be called upon to treat this very painful, and oftentimes stubborn ailment.

I have had most satisfactory results from the following treatment. when called to prescribe for a case of dysentery—no matter at what stage—if there be much pain and tenesmus. I begin by giving:—

Chloral Hyd.	gr. xl.
Magnesia Sulph.	3 vj.
Aqua Camphora	qs. ft. 3 iiij.

**M et S.**

One tablespoonful every hour till a free evacuation is obtained.—It is wonderful the amount of relief this will give,—and in a mild case I order it continued, in lessened doses and at longer intervals, for twelve to twenty-four hours longer and give no other medicine.

When the case is more severe and there is much elevation of temperature, I give indicated sedative with acidulated drinks, and after having obtained a thorough cleansing of the intestinal tract with the first prescription, I give:—

R.	Pul. Camphor	—	
	Pul. Opii	aa	1 part.
	Pul. Carbo. Lig.		2 "
	Bis. Sub. Nit		10 "

**M** These I give in such doses as may be required to control all pain, and hold in check the alvine evacuations. This will affnrd the patient much comfort; and needed quiet and rest; and will often end the disease.

In still more stubborn cases, it may be necessary to repeat the *physic* every second or third day, following each time with the powder, till the disease is brought under control. In malarial districts also add an antimalaria treatment.

Malignant epidemics will call for an energetic anti-septic and anti-zymadtic medication.

V.

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## SUBSCRIPTIONS.

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Amounts received during March for subscriptions:

A. E. Scott,	\$1.00.	T. S. Morton,	\$1.00.
A. S. Cook,	1.00.	C. S. Clark,	1.00.
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Every fluid drachm contains 15 grains EACH of Pure Chloral Hydrat. and purified Brom. Pot., and one-eighth grain EACH of gen. imp. ext. Cannabis Ind. and Hyoscyam.

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One-half to one fluid drachm in WATER or SYRUP every hour, until sleep is produced.

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**IT DOES NOT LOCK UP THE SECRETIONS.**

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Papine is the Anodyne or pain-relieving principle of Opium, the Narcotic and Convulsive Elements being eliminated. It has less tendency to cause Nausea, Vomiting, Constipation, Etc.

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Same as Opium or Morphia.

### DOSE.—

(ONE FLUID DRACHM)—represents the Anodyne principle of one-eighth grain of Morphia.

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Iodia is a combination of active principles obtained from the Green Roots of Stillingia, Helonias, Saxifraga, Menispermum, and Aromatics. Each fluid drachm also contains five grains Iod. Potas., and three grains Phos. Iron.

### DOSE.—

One or two fluid drachms (more or less as indicated) three times a day, before meals.

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Syphilitic, Scrofulous and Cutaneous Diseases, Dysmenorrhea, Menorrhagia, Leucorrhea, Amenorrhea, Impaired Vitality, Habitual Abortions, and General Uterine Debility.

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